APPENDIX 1.

EXCERPTS FROM ILLINOIS INSURANCE CODE OF 1937 (Ch. 73, Ill. R. S.).

"ARTICLE I * * * CLASSIFICATIONS.

* * * * *

Sec. 4 [Ch. 73, Ill. R. S., Par. 616] **Classes of Insurance.**

Insurance and insurance business shall be classified as follows:

Class 1. Life, Accident, and Health.

* * * * *

(b) Accident and Health. Insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age and every insurance appertaining thereto."

"ARTICLE IX—PROVISIONS APPLICABLE TO ALL COMPANIES.

Sec. 132 [Ch. 73, Ill. R. S., Par. 744] **Examinations.**

(1) The Director, for the purpose of ascertaining the assets, conditions and affairs of any company, may examine the books, records, documents and assets of

(a) any company transacting, or being organized to transact, business in this State;

* * * * *

(d) any person having a contract, written or oral, pertaining to the management or control of a company as exclusive general agent.

(2) Every company or person being examined, its officers and agents, shall produce at its office its books, records and documents and all or any papers in its or their possession relating to the property, assets, business or affairs of the company. * * *

(3) The examiners designated by the Director pursuant to Section 402, shall make a full and true report of every examination made by them, which shall

comprise only facts ascertained from the books, papers, records or documents, examined by them or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business and affairs and the assets of such company or person. * * *

* * * * *

Sec. 141 [Ch. 73, Ill. R. S., Par. 753] **Exclusive Agency Contracts.**

(1) No domestic company authorized to do an insurance business in this State shall make a contract with any person whereby such person is granted the exclusive right or privilege to solicit, procure, write or produce the entire insurance business for such company and collect premiums therefor unless such contract is filed with and approved by the Director. Failure of the Director to disapprove any such contract within thirty days after the same shall be filed with him, shall constitute his approval thereof. * * *

(2) The Director shall not approve any such contract which

(a) subjects the company to excessive charges for expenses or commissions; * * *.

Sec. 143 [Ch. 73, R. S., Par. 755] **Policy Forms—Life, Accident and Health.**

(1) No company transacting the kind or kinds of business enumerated in Class 1 of section 4 shall issue or deliver in this State a policy or certificate of insurance, * * * or use an application blank, in this State until the form and content of such policy, certificate, * * * or application blank has been filed with and approved by the Director. *It shall be the duty of the Director to withhold approval of any such policy,* certificate, * * * or application blank filed with him *if it violates any provisions of this Code, contains inconsistent, ambiguous or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy.* In all

other cases the Director shall give his approval. Failure of the Director to act within thirty days after submission shall constitute approval. * * *

[Italics are ours here and elsewhere unless otherwise stated.]

Sec. 149 [Ch. 73, Ill. R. S., Par. 7611 **Misrepresentation * * * Prohibited.**

(1) No company doing business in this State, and no officer, director, agent, clerk or employee thereof, broker, or any other person, shall make, issue or circulate or cause or knowingly permit to be made, issued or circulated any estimate, illustration, circular or verbal or written statement of any sort misrepresenting the terms of any policy issued or to be issued by it or any other company or the benefits or advantages promised thereby * * *.

* * * * *

(5) Any company, officer, director, agent, clerk or employee thereof, broker, or other person who violates any of the provisions of this section, or knowingly participates in or abets such violation, shall be required to pay a penalty of not less than one hundred dollars, nor more than one thousand dollars, * * *."

"ARTICLE XVI—ASSESSMENT LEGAL RESERVE LIFE COMPANIES.

Sec. 254 [Ch. 73, Ill. R. S., Par. 866] **Scope of Article.**

This article shall apply to

(a) all companies transacting or being organized to transact the kind or kinds of business described in Class 1 of section 4 upon an assessment legal reserve basis;

* * * * *

Sec. 261 [Ch. 73, Ill. R. S., Par. 873] **Documents to Be Delivered to the Director.**

Upon the execution of the articles of incorporation there shall be delivered to the Director

(a) duplicate originals of the articles of incorporation;

(b) a copy of the by-laws adopted by the incorporators;

(c) forms of applications for insurance;

(d) forms of insurance policies, literature and advertisements;

(e) forms for guarantee fund subscriptions and certificates, if any; and

(f) two organization bonds or the cash or securities, provided for in section 262.

Sec. 267 [Ch. 73, Ill. R. S., Par. 879] **Subscription Requirements—Surplus.**

(1) No assessment legal reserve life company shall receive a certificate of authority from the Director to transact an insurance business unless it has five hundred bona fide applications from five hundred members for life insurance in the aggregate of at least two hundred and fifty thousand dollars, or unless it has two hundred and fifty bona fide applications from two hundred and fifty persons for life insurance in the aggregate of at least one hundred and twenty-five thousand dollars, and a surplus of at least ten thousand dollars.

* * * * *

Sec. 268 [Ch. 73, Ill. R. S., Par. 880] **Guarantee Fund.**

(1) Any domestic company subject to the provisions of this article may provide for a guarantee fund in the minimum sum of ten thousand dollars and the maximum sum of one hundred and fifty thousand dollars, for the purpose of its business or to enable it to comply with any requirements of the law. Such guarantee fund and such interest thereon as may have been agreed upon, not exceeding seven per centum per annum, shall not be a liability or claim against the company or any of its assets except as herein provided and such interest shall be paid and such principal shall be retired only out of the earned surplus of the company. * * *"

* * * * *

"ARTICLE XX—ACCIDENT AND HEALTH INSURANCE.

Sec. 355 [Ch. 73, Ill. R. S., Par. 967] **Accident and Health Policies—Provisions.**

No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued * * * until a copy of the form thereof and of the classification or risks * * * have been filed with the Director; nor shall it be so issued * * * until * * * thirty days after it has been so filed unless the Director shall sooner give his written approval thereto. If the Director disapproves the policy form he shall make a written decision stating the respects in which such form does not comply with the requirements of law * * * and it shall be unlawful thereafter for any such company to issue any policy in such form.

Sec. 356 [Ch. 73, Ill. R. S., Par. 968] **Form and Content of Policy.**

(1) No such policy shall be issued or delivered

* * * * *

(d) unless every printed portion thereof and of any endorsement or attached papers shall be plainly printed in type of which the face shall not be smaller than ten point; nor * * *

(f) unless the exceptions of the policy be printed with the same prominence as the benefits to which they apply.

Any portion of such policy which purports, by reason of the circumstances under which a loss is incurred, to reduce any indemnity promised therein to any amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed in bold face type and with greater prominence than any other portion of the text of the policy.

Sec. 357 [Ch. 73, Ill. R. S., Par. 969] **Standard Provisions.**

Every such policy so issued shall contain certain standard provisions, which shall be in the words and

in the order hereinafter set forth and be preceded in every policy by the caption, 'Standard Provisions.' * * *

* * * * *

(4) A standard provision relative to time of notice of claim which may be in either of the three following forms: * * * Form (C) to be used in policies which insure against loss from both accident and sickness. * * *

* * * * *

(C) 4. Written notice of injury or of sickness on which claim may be based must be given to the insurer within twenty days after the date of the accident causing such injury or within ten days after the commencement of disability from such sickness.

(5) A standard provision relative to sufficiency of notice of claim which shall be in the following form and in which the insurer shall insert in the blank space such office and its location as it may desire to designate for such purpose of notice.

5. Such notice given by or in behalf of the insured or beneficiary, as the case may be, to the insurer at ..... or to any authorized agent of the insurer, with particulars sufficient to identify the insured, shall be deemed to be notice to the insurer. Failure to give notice within the time provided in this policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible."

"ARTICLE XXIV—DIRECTOR OF INSURANCE, HEARINGS AND REVIEW.

Sec. 401 [Ch. 73, Ill. R. S., Par. 1013] **General Powers of the Director.**

The Director is charged with the rights, powers and duties appertaining to the enforcement and execution of all the insurance laws of this State. He shall have the power

(a) to make reasonable rules and regulations as may be necessary for making effective such laws;

(b) to conduct such investigations as may be necessary to determine whether any person has violated any provision of such insurance laws; and

(c) to conduct such examinations, investigations and hearings in addition to those specifically provided for, as may be necessary and proper for the efficient administration of the insurance laws of this State.

* * * * *

Sec. 407 [Ch. 73, Ill. R. S., Par. 1019] **Court Review of Orders and Decisions.**

Any order or decision made, issued or executed by the Director, except an order to make good an impairment of capital or surplus or a deficiency in the amount of admitted assets, whereby any company or person is aggrieved, shall be subject to review by the Circuit Court of Sangamon County or the Circuit or Superior Court of the county in which the principal office in this State of the company aggrieved by such order or decision is located, or where the person so aggrieved resides. * * *''

''Article XXVIII—Final Provisions.

* * * * *

Sec. 446 [Ch. 73, Ill. R. S., Par. 1058] **Penalties.**

Any person who violates any of the provisions of this Code, or fails to comply with any duty imposed upon him or it by any provision of this law, for which violation or failure no penalty is elsewhere provided by the laws of this State, shall be fined not exceeding five hundred dollars.''

APPENDIX 2.

SYNOPSIS OF INSURANCE POLICIES IN SUIT.

The petitioner insurance company and its predecessors issued a number of different health and accident policies and also a number of endowment and life insurance policies (R. 809, 828-9). Two of the health and accident policies, the Security and the American Sentinel policies, are here under attack. Both policies were approved by the State and issued pursuant to State authority (R. 172). Photographic copies of the policies (reduced to half size) are set forth at page 469 of the transcript.

The Security policy was issued in several forms (all substantially alike) of which Forms L-101 and L-102 (Govt. Exs. 9 and 12) are here involved. The American Sentinel Policy was known as Form L-105 (Govt. Ex. 13).

Of the 13 policyholders alleged in the indictment to have been defrauded (omitting the 4 named in the counts that were dismissed) one had Security Policy Form L-101 (Govt. Ex. 9); 10 had Security Policy Form L-102 (Govt. Ex. 12); and 2 had the American Sentinel Policy (Govt. Ex. 13). Of 9 other policyholders testifying, one had a Security Policy Form L-101 and the 8 others had Security Policy Form L-102.

There is no substantial difference between Security Policy L-101 and L-102 except that in Form L-101 the benefit payable on death from a travel accident increases from $2,500 to $3,750 in 5 years, while in Form L-102 the increase is to $5,000. Otherwise, so far as here material, the 2 forms of Security Policy are the same.

The Security Policy.

The Security Policy was the first policy issued.

The material features of the policy are thus summarized:

In a box on the cover, under the heading "Important Notice," is the direction in bold face type—"**Read your policy carefully * * *.**"

On the first page, in large bold face type, is the heading, "**LIMITED ACCIDENT AND SICKNESS POLICY.**"

Diagonally across the front of the policy, in large colored capital letters, is the warning, "**THIS IS A LIMITED POLICY, READ IT CAREFULLY.**"

Then follow provisions relating to injuries from specific accidents, comprising the following:

Part I—a list of specific benefits for loss of life, loss of sight, etc., under the heading, in capital letters, "DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS—TRAVEL ACCIDENTS."

Part II—a description of the various types of accidents, to which the indemnities specified in Part II apply, each set forth in capital letters, including losses resulting from the wrecking of any of the following vehicles in which the insured might be a passenger: a passenger elevator, bus, private automobile (used for pleasure), motorcycle. The definition of "wrecking" is set forth in a prominent place at the top of the first page of the policy.

Part III—a schedule of alternative, optional indemnities for specific accidents listed in Part II.

Part VI—a provision for hospital benefits of $25 per week for 4 weeks for confinement in a hospital for injuries resulting from any cause listed in Part II.

The following provision is made for loss resulting from specified illnesses:

Part IX—a provision for $25 per week for a period of confinement beginning after the first 7 days and not exceeding 10 weeks because of any one of 56 listed diseases, including most of the common ailments.

This list was made up, presumably by the actuary, at the time of preparation of the first policy and is in the form approved by the Department of Insurance (Govt. Ex. 9, R. 469; Defts.' Ex. 10, R. 767).

There was testimony by a physician, put on the stand by the Government, that 21 of the diseases listed would not confine the patient for 7 days, or would kill him before that time expired (R. 135-137). But experience of the company indicates that at least, in some cases, confinement for the required period could and would result from some of the 21 diseases referred to (R. 190).

In any event, the remaining 35 of the diseases, including many common ailments, could cause confinement for the period specified (R. 137-138).

In addition to the above provisions for the special types of accidents and illnesses covered by the policy, the following indemnities are allowed for losses resulting from other accidents and illnesses not listed:

> Part IV—$100 for death from any unlisted accident.
>
> Part V—$25 for confinement of more than 30 days resulting from any unlisted accident.
>
> Part X—$15 for confinement (Form L-102, Govt. Ex. 12, R. 469; $25 is allowed in Form L-101, Govt. Ex. 9, R. 469) of more than 30 days from any illness not listed.
>
> Part XII sets forth the "Standard Provisions" as required by statute (Sec. 357, Ill. Ins. Code; Ch. 73, Ill. R. S. Par. 969). Standard Provisions 4 and 5, relating to notice, are all that are important here. They follow the statutory form set forth in Sec. 357, p. 69, *post.*
>
> Part XIII contains the "General Provisions" relating to rights and obligations of the insured, and certain definitions, exceptions and limitations applicable in construing the policy, of which the following only have any importance in this case:
>
> "* * *

(c) * * * After the age of sixty years all benefits and indemnities hereunder shall be reduced one-half.

(d) This insurance does not cover * * * (3) miners while at work; * * *; * * * (10) injuries fatal or non-fatal except drowning of which there shall be no mark or contusion on exterior of the body at the place of injury * * *; * * * (14) * * * post-traumatic infection * * *.

* * *

(j) The insurance under this policy shall not cover any loss or disability caused by diseases or illnesses affecting organs not common to both sexes. * * *''

All the foregoing qualifying provisions are in bold face type.

No fine type is used in the policy.

The American Sentinel Policy.

The ''American Sentinel Policy'' (Form L-105, Govt. Ex. 13, R. 469) is broader in its application than the Security Policy. The Sentinel Policy gives indemnity for loss from all types of injuries and sicknesses, subject to limitations and exceptions that are substantially the same as in the Security Policy.

The indemnity provisions and limitations and qualifications thereof are clearly set forth in capital letters or bold face type.

At the top of the policy in large, bold face capital letters, is a statement that the policy provides for **''INDEMNITY FOR LOSS OF LIFE, LIMBS, SIGHT AND TIME BY ACCIDENTAL MEANS OR TIME BY SICKNESS TO THE EXTENT HEREIN PROVIDED.''** Also in bold face capitals are the statements **''ACCIDENTAL DEATH BENEFIT $1,000''** and **''TRAVEL ACCIDENT DEATH BENEFIT $3,000.''**

In bold face type at the bottom of the first page of the policy is the statement, "**Benefits Reduced After Age 60.**"

The body of the policy is divided into 17 parts. Parts I, II and III set forth the conditions under which the single, double or triple indemnities are paid, for the specific losses listed. The single indemnity is payable for specific losses resulting from any accident; double indemnity, from specific losses suffered while riding in a pleasure automobile or other vehicle of the pleasure type, in case of the wreck of the vehicle; triple indemnity for losses suffered while riding as a passenger on a car or boat operated by a common carrier, in case of wreck of the car or boat.

So far as material, the other parts of the policy provide as follows:

> Part IV provides for indemnity, in case of loss of time resulting from accidental injury, of $50 per month for the first month, and $100 per month thereafter, up to a total period not exceeding 10 weeks, for the time the insured is disabled and confined to his house (except for necessary visits to the doctor's office).
>
> Part V provides for payment of $25 per month for the first 30 days and $100 per month thereafter, for a period of not exceeding 8 weeks, during which the insured shall be totally disabled and unable to attend to any labor or business because of an illness not excepted under the policy.
>
> Part VI provides for certain optional indemnities for specific injuries.
>
> Part VII provides for additional hospital benefits of $3. per day, not exceeding 15 days.
>
> Part VIII provides for an additional benefit of $10 for physician's or surgeon's services for which an indemnity is not otherwise payable under the policy.
>
> Part XI provides that accidental injuries resulting in certain diseased conditions including boils, septicaemia, and sprained or lame back, shall be paid for under Part V, relating to sicknesses—rather than under the accident provisions.

Part XII provides for expenditure of not more than $100 to locate relatives of the insured in case of emergency.

Part XIII sets up separately in bold face type, under the heading, "REDUCTIONS AND LIMITATIONS" certain exclusions and exceptions which are substantially the same as those set forth in Part XIII of the Security Policy (summarized pp. x-xi, *ante*).

Part XIV provides that after the insured reaches the age of 60 years, benefits and indemnities are reduced by one-half.

Part XVI contains the standard provisions prescribed by statute, including Provisions Nos. 4 and 5 relating to notice. (See Sec. 357, Illinois Insurance Code, Appendix 1, p. vi.)

Provision No. 4 is set forth in bold face type.

APPENDIX 3.

The Advertising.

The Government put in evidence 12 circular letters and 12 published advertisements relating to the policies in suit (R. 673-717).

The opinion filed (R. 919-37) quotes from 11 of the circular letters (only 6 of which were used) and from 2 of the published advertisements.

The advertisements do not purport to contain a statement of all the conditions and limitations in the policy advertised, or of the procedure that the insured must follow in presenting a claim. The purpose of each advertisement is to induce readers to send for the policy advertised, to examine it, and, if found satisfactory, to purchase it or retain it.

The superlatives used in describing this "remarkable policy," setting forth the "vital protection" afforded by it, and the necessity for getting "real cash money to pay doctor and medicine bills and regular living expenses," etc., are contained in the letters submitted to and approved by the Department of Insurance in June, 1910 (R. 760-4).

The opinion (R. 926) states that the evidence tends to show "substantial misrepresentation in the circular letters and advertisements"; and (R. 927) that "the testimony of policyholders tended to show that various of the inducements to the applicants contained in the letters and advertising had been actually misleading."

This is not borne out by the record.

1.

The Advertising Contains No Misstatement of a Material Fact.

(a)

The opinion states (R. 926) that the advertisements do not point out that the indemnities are "for certain specified accidents and certain specified illnesses."

That statement is not supported by the facts. Each of the advertisements that purports to list the benefits in the policies (except one of the published advertisements (R. 717) which speaks of "*graded*" benefits) states that those benefits are paid for "*specified*" accidents or illnesses, or that accidents or illnesses covered, or payments therefor, are "*as specified in the policy,*" "*all as stated in the policy,*" or the like,—substantially in accord with the form approved by the State Department of Insurance in 1940 (R. 760-763).

The policies advertised (R. 469 *et seq.*) set forth the limitations referred to.

(b)

The opinion (R. 926) cites as a misrepresentation the failure of the advertising to state that the specified maximum indemnities are for "travel" or "public carrier" accidents or the like.

The statement referred to was omitted from many of the advertisements, but not from all.

The first circular letter quoted in the Court's opinion includes a statement as to travel accidents which the opinion omits. The quotation in the opinion (R. 922) reads as follows:

> "Think of receiving $25.00 in cash each week to help you through a long period of disability * * *. In addition the policy provides up to $8,000 cash death benefits."

That quotation omits a sentence in the letter (indicated by the asterisks, following the phrase "long period of disability"), reading as follows (R. 673):

> "This Marvelous Policy pays death and disability benefits in case of accidents occurring while riding on a railroad car, elevated, subway, or interurban car, electric street-car, steamboat, taxicab, automobiles, motorcycles, horse-drawn vehicles, explosions, burning buildings, being struck by lightning, cyclone, or tornado—accidents in the home, And Many Other Liberal Generous Features."

This circular letter therefore contains all information that could be asked with respect to the kind of accidents covered by the Security Policy for which maximum indemnities are payable.

Other advertisements omit the statement that certain maximum benefits are limited to travel accidents—but rely on the qualification "*maximum*" or "*up to*" the amount stated, or on the phrases "*specified accident,*" "*specified illness,*" or "*as specified in the policy,*" or the like to indicate the limitation. Omission of the specific reference to "travel accidents" or "public carrier" accidents is not a misrepresentation of fact.

While the State Insurance Department (which has exclusive jurisdiction of this matter) in its letter of June 3, 1940 (R. 752-3) suggested that the qualification "public carrier" be added to describe an accidental death for which certain benefits were payable, no complaint was thereafter made by the Department to the omission of that phrase, or to the use of substitute phrases in later advertising—despite periodic examinations and exhaustive reports by the Department over the subsequent 8-year period, with respect to every detail of the business.

In view of the fact that the Department, in its letter of November 27, 1940 (R. 764-5) stated expressly that it was

not "waiving any of its duties with respect to the enforcement of the provisions of the Illinois Insurance Code concerning advertising which misrepresents the terms of the policies advertised," the failure of the Department to object to the advertising matter thereafter used is convincing evidence that there was no objection to it.

In the policies themselves, the limitations affecting the amount of the benefits and the character of accidents for which paid are set forth in boldface or capital letters (R. 469).

(c)

The opinion (R. 926) cites as a misrepresentation the fact that the advertisements contain no reference to a requirement in the policy that in certain cases a disability must persist for 30 days before maximum compensation or in some instances, any compensation, is payable therefor.

It is not fraudulent not to state all qualifications and limitations in an advertisement. The requirement of a minimum disability period of 30 days, more or less, is usual in health policies unless the premium is very high. Each advertisement refers the applicant to the policy for the specific terms under which benefits are payable.

(d)

The opinion (R. 926) criticizes the statement in the advertising that anyone between the ages of 16 and 75 could be insured, whereas the policy showed that all benefits are reduced by one-half after age 60.

Some of the circular letters sent out call specific attention to the fact that the benefits are reduced by half after age 60. See, for example, circular letter sent to Roman P. Penez and given by him to Nicholas P. Salazar (Govt.

Ex. 114; R. 715-6) not referred to in the opinion, which sets forth that half benefits are paid after age 60.

Other circulars did not call attention to that provision; but it is common in insurance policies and was set forth in boldface type in each of the policies here involved.

No one was misled by omission in the advertising of reference to reduction in benefits after age 60.

Of the 4 witnesses whose claims were reduced because of age, only one (Lowrey) had seen any advertising, and he testified that he knew when he got his policy that benefits were reduced by one-half after age 60 (R. 75).

Two out of the other 3 claimants mentioned also knew, when they received their policies, of the existence of the provision for reduction on account of age (R. 93, 555).

(e)

The opinion (R. 926) criticizes the statement in the advertising that no physical examination is required.

That statement is strictly accurate. No physical examination was required from any applicant for insurance.

Each applicant was required in his application for insurance to state that he was then in good health. If that statement is not true, it is the applicant, and not the insurance company, who is guilty of fraud. If the insurance company suspects that a fraud has been committed, investigation of the facts as to the health of the insured at the time of his application, is called for. The fact that such an investigation is made in no way detracts from the truth or significance of the fact that the applicant does not have to submit to a physical examination.

(f)

The opinion (R. 926) cites the fact that the advertising does not state that benefits would not be paid for disability resulting from a disease of an organ not common to both sexes.

Again the criticism is of the failure of the advertising to list limitations in the policy—which would be impracticable, if not impossible.

The attack is directed at the policy, not at the advertising. Without the limitation complained of, the premium for health insurance would be much higher.

The provision is a common one and while there has been considerable litigation as to its proper construction, its fairness or validity does not seem to have been questioned. (*Crisman* v. *Fidelity Health and Accident Mutual Insurance Co.*, 95 N. E. 2nd 776 [Ohio App.]; *Mutual Benefit Health and Accident Association* v. *Blaylock*, 87 A. L. R. 679 [Miss.]).

(g)

The opinion (R. 926) criticizes the statement that there is a "$100 emergency cash benefit."

Payment of this benefit is provided for in Part XI of the Security Policy and Part XII of the American Sentinel Policy, to pay expenses that might be incurred by an injured policyholder in getting in touch with friends and relatives. There is no basis for finding this statement to be a misrepresentation.

(h)

The opinion (R. 926) lists as a misrepresentation the statement that the "complete coverage" policy "had no loopholes, no ifs, ands or buts, no tricky wording, and no legal catch phrases."

The "complete coverage" or American Sentinel policy is a broad policy and is not restricted to specified illnesses. An examination of the policy form (Govt. Ex. 13 following Tr. 468) will show that reductions, limitations and conditions are set forth in boldface type under appropriate headings so that they could hardly be missed.

The designation of this policy as a "complete coverage" policy as well as the terms of the policy itself were approved by the State Department of Insurance.

The statement is not a misrepresentation.

(i)

The opinion (R. 926-7) also characterizes as untrue the statements that, "thousands of claims have been paid," "only a limited number of policies are to be issued," and "payments of benefits are guaranteed by a staunch old company."

The statement that the number of policies that could be issued is limited (if of any importance) is true—because of the requirements of the Illinois Insurance Code as to the maintenance of reserve and surplus funds. When those funds were unduly reduced, more guarantee certificates had to be sold, or the risks had to be reinsured to enable the company to continue issuing policies. In order to assure adequate reserves, all principal sums on outstanding policies were reinsured (R. 810).

The statement that the company was reliable was true. Financial requirements as to reserves and surplus were

complied with and claims were paid in strict accordance with the policy provisions. This appears from every report rendered by the Department of Insurance on investigation of the company (R. 775-6, 790-1, 807, 825).

Whether or not statements that the company was "old" or had paid "thousands of claims" were exaggerations, is of no importance. No one could have been hurt thereby.

The statements referred to could furnish no basis for a charge of fraud.

(j)

The opinion (R. 927) refers to the promise to furnish "quick cash when you need it most," but the Court states there was a delay of 52 days between the filing of a claim and the payment.

This is not a fair criticism. It conflicts directly with the finding by the Illinois Insurance Department for the years 1945-8 that *"policy claims appear to be paid promptly and in accordance with policy provisions"* (R. 825).

The fifty-two days' elapsed time referred to was from receipt of the preliminary "notice of sickness or injury on which a claim may be based" required by the statutory Standard Provision 4—not from the date of filing of the claim. The claim would not mature and could not be filed for a considerable period (at least 30 days in many instances) after the preliminary notice was given, and sufficient information to warrant payment of the claim might not be then forthcoming for an extended period.

The evidence does not show undue delay in payment of claims in accordance with policy provisions—certainly no delay from which a charge of fraud would be inferred.

2.

The Testimony Does Not Show That Any Policyholder Was Misled by the Advertising.

The opinion (R. 927) stated that "the testimony of the policyholders tended to show that various inducements to the applicants contained in the letters and advertising had been actually misleading."

The record does not support that statement.

Of the 22 policyholders testifying, 15 did not identify any advertising matter that they had seen, and made no claim that they had been misled by any advertising.

As to them, the case rests wholly on the charge that the state-approved policies were themselves deceptive and fraudulent.

Of the remaining 7 who identified circular letters or advertisements, seen by them before they bought their policies, none stated that he had been misled by this advertising.

(a)

Three of the policyholders (Edgar E. Hewatt, R. 66-72, 493-9; Emmitt P. Longan, R. 106-8, 618-629; and Major Brown, R. 99-100, 635-642), received one or both of two circular letters from defendant Johnson (R. 699-702) referred to in the Court's opinion (pp. 924-5) stating that the Security Policy paid "a maximum benefit of $5,000 for specified accidental death, or specified loss of hands, feet or eyesight; benefits of $25 each week for specified accidents; $100 per month — monthly benefits for disability due to sickness * * * as stated in the amazing Arcadia policy"; and asking the reader to send for and examine the policy.

Hewatt's claim was rejected because he failed to give notice for several months after his illness began, whereas,

by Standard Provision 4 (p. vi *ante*—required to be in the policy by express provision of the state law) notice must be given within 10 days. The letter rejecting the claim informed Hewatt that the failure to give notice would be waived and that the claim would be reinstated, as provided in Standard Provision 5 (p. vi *ante*), in the event it was not reasonably possible to give notice within the time specified.

There is no basis for a claim that Hewatt was misled by any statement in the circular he received. The criticism is of the policy provision calling for notice within 10 days, and of the statute requiring it.

Longan was hurt by a wreck of a truck which was a type of accident not "specified" in the policy and hence not calling for the indemnity payable for specified accidents. The word "specified" in the circular letter he received must be given some weight, and implies that there are accidents not specified, and not enumerated in the advertisement, for which the maximum benefit is not payable. He was asked in the circular to send for and to examine the policy before taking it.

Major Brown had bronchitis with influenza, confining him to his home for two weeks. This was likewise not a "specified" illness; and since the claimant was not confined to his home for 30 days, no benefit was payable. There is nothing in the testimony or correspondence to show that he was misled.

(b)

Raphael O. Lowery received two letters outlining the maximum benefits paid by the Security policy which he purchased (Govt. Exs. 59-60, R. 686-690).

He received one-half the benefit specified because he was over 60 years old. He testified that when he received the policy he read it and knew he would get only one-half (R. 75). He was not misled by the advertising.

There were 3 other witnesses (York, Long and DeSloover) whose claims were reduced because they were over age 60 but who did not identify any advertising that they had received. There was only one of those who had not known before making his claim, that benefits would be reduced by one-half because of age.

York had made a prior claim which was reduced one-half on account of age (R. 555). Long testified that he had read his policy when he got it and knew that it paid only one-half benefits after age 60 (R. 93). DeSloover, alone, said that he had not known that the claim would be reduced half after 60, but he did not identify any advertising that he saw and made no claim that he had been misled (R. 102-3).

(c)

Nicholas P. Salazar (R. 117-120; 504-13) was given a letter addressed to his brother-in-law, Roman P. Penez (Govt. Ex. 114; R. 715-6) stating that the Security policy "provides $25 weekly indemnity for sickness or accident and the maximum of $2,500 accumulating to $5,000 in five years for accidental death, all as specified in the policy * * * also * * * special sickness, accident and death indemnity, hospital benefits, surgeon fees and other vital protection." The letter stated that one-half benefits are paid after age 60, but that there are no increases in rates at any time.

The letter was thus very fair in stating the terms of the policy.

Salazar had eczema which was one of the illnesses specified by the policy, but his claim was rejected because he was not confined for 7 days, as required by the policy (R. 509).

There is nothing in the advertising that could have misled him.

(d)

Irene N. Dawson (R. 77-9; 574-590) received a circular letter (Govt. Ex. 79, same as Govt. Ex. 71, R. 703) calling attention to the fact that the policy pays "$5,000 maximum for accidental death, loss of feet or hands, with a maximum of $1,875 for the loss of one foot or hand * * * large cash monthly payments if disabled by sickness and accident all as explained and specified in the policy itself." The circular asked her to send for the policy and to read it carefully.

Miss Dawson stepped on a tack, resulting in an infection of her foot—although on the facts it is quite doubtful that the disability for which her claim was made actually resulted from the tack injury, instead of from a stroke or pulmonary tuberculosis with which she was afflicted (R. 579-587).

In any event, her claim was rejected because it was for a post-traumatic infection, excepted from coverage by specific provision of the policy.

If any exception is taken to the handling of this claim, it is on account of the provisions of the policy itself. There is nothing in the advertising that misstated any material fact or misled the claimant.

(e)

James Herbert Scarborough saw an advertisement in The Farmers Almanac (R. 717).

The advertisement was under a heading, "Cash for Sickness—for Accident," and stated that the policy "pays graded benefits of $2,500 for accidental loss of life, limb, sight, etc."

The claim was for an "acute" back sprain. The accident occurring while the claimant was on duty at a coal mine, requiring his confinement in a hospital for 16 days and disability for a somewhat longer period. The claim was re-

jected because there was no visible wound or contusion and the injury was received by a miner while at work, both of which were among the exceptions from coverage set forth in the policy.

While the term "graded benefits" in the published advertisement is not as explicit as the references in the circular letter to limitations in the policy, there is no ground for claiming that there was any misleading information given which affected this insured's claim. A short magazine advertisement could not list all qualifying provisions of the policy.

The Security policy was a limited policy and a warning to that effect was stamped upon it.

From the foregoing it appears that none of the seven witnesses who had seen any advertising matter before getting their policies, was misled thereby into buying a policy that he would not otherwise have taken. In each case, in compliance with the request in the circular or advertisement, he had sent for and examined the policy and decided to keep it. There is no evidence that the advertising deceived him.

The other fifteen policyholders who testified did not identify any advertising matter and made no claim to have been misled thereby into buying a policy.

The purpose of the advertising was to induce the reader of it to send for, to examine, and to keep the policy advertised—but if he did not like it he was given the right to return it.

The policy referred to sets forth the applicable terms, limitations and conditions, in the form prescribed by the state statute for the purpose of making sure that the pur-

chaser of the policy should not be deceived as to the provisions of his contract.

In considering whether a fraud was contemplated, the policy must be considered along with the advertising matter tendering it.